Articles

Physician-Patient Sexual Contact
Prevalence and Problems

NANETTE K. GARTRELL, MD; NANCY MILLIKEN, MD; WILLIAM H. GOODSON III, MD; SUE THIEMANN, MS; *and* BERNARD LO, MD, *San Francisco, California*

To document the current prevalence of physician-patient sexual contact and to estimate its effect on involved patients, 10,000 family practitioners, internists, obstetrician-gynecologists, and surgeons were surveyed. Of the 1,891 respondents, 9% acknowledged sexual contact with 1 or more patients. Even in the unlikely case that none of the nonrespondents had sexual contact with patients, its prevalence among all 10,000 physicians surveyed would still be 2%. Of respondents, 23% had at least 1 patient who reported sexual contact with another physician; 63% thought this contact was "always harmful" to the patients. Almost all (94%) responding physicians opposed sexual contact with current patients; 37% also opposed sexual contact with former patients. More than half of respondents (56%) indicated that physician-patient sexual contact had never been addressed in their training; only 3% had participated in a continuing education course focusing on this issue. Clear and enforceable medical ethics codes concerning physician-patient sexual contact are needed, as well as preventive educational programs for medical schools and residency programs.

(Gartrell NK, Milliken N, Goodson WH III, Thiemann S, Lo B: Physician-patient sexual contact—Prevalence and problems. West J Med 1992 Aug; 157:139-143)

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relationships with both female and male persons, be they free or slaves.

HIPPOCRATIC OATH
4TH CENTURY BCE[1]

Sexual contact which occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and may ultimately be detrimental to the patient's well-being.

AMERICAN MEDICAL ASSOCIATION
COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[2]

Concern about physician-patient sexual contact dates as far back as the Hippocratic treatise. Although the harm done by such contact has been well documented,[3-6] the prevalence of sexual contact between patients and physicians who are not psychiatrists has never been reliably established. Existing estimates are based on two small, geographically restricted surveys.[7,8] To document the current prevalence of physician-patient sexual contact, we surveyed randomly selected national samples of family practitioners, internists, obstetrician-gynecologists, and surgeons. We defined sexual contacts conservatively, excluding spouses, significant others, and sexual partners who later became patients. The survey was designed to address the following questions:

- How prevalent is physician-patient sexual contact?
- What are the opinions of physicians regarding sexual contact with patients?
- How are patients affected by sexual contact with physicians?

Methods

The 33-item anonymous questionnaire in this study was modified from the instrument developed by Gartrell and colleagues for 1985 and 1986 surveys of psychiatrists.[9,10] It contained 7 items on demographics, 4 on respondents' opinions, 2 on their education concerning physician-patient sexual contact, and 20 items on respondents' personal experiences with their patients. The questions on personal experience included four regarding patients who had been sexually involved with previous physicians and who were subsequently treated by the respondents. The remainder of the personal experience questions focused on the respondents' sexual contacts with their own patients. Physicians who answered affirmatively to sexual contact with patients were asked to specify the number of female and male patients with whom they had had sexual contact and were then asked a series of questions about their most recent sexual contact. These questions included a request to specify how long the physician had engaged in sexual contact with the patient and the nature of the medical treatment at the beginning of the sexual contact.

Sexual contact was defined in behavioral terms as physical "contact that arouses or satisfies sexual desire in the patient, physician, or both." Although the word "patient" referred to anyone the respondent had ever treated, physicians who had treated spouses, significant others, and sexual partners who later became patients were excluded from the pool of those who acknowledged sexual contact with patients. We decided on this exclusion because many physicians believe that treating one's spouse or significant other is not unethical. Therefore, our definition was conservative, and

From the Departments of Psychiatry (Dr Gartrell); Obstetrics, Gynecology, and Reproductive Sciences (Dr Milliken); Surgery (Dr Goodson); and Medicine (Dr Lo) and the Program in Medical Ethics (Drs Lo and Milliken), University of California, San Francisco. Ms Thiemann is a statistician in private practice.

Reprint requests to Nanette K. Gartrell, MD, 3570 Clay St, San Francisco, CA 94118.

we studied only physician-patient sexual contact that began during or after medical treatment.

The study population consisted of 10,000 physicians in the United States randomly selected by specialty from the American Medical Association (AMA)'s master file of physicians—members and nonmembers—who had completed training and who were currently practicing clinical medicine. The sample included 3,000 family practitioners, 2,000 internists, 2,000 obstetrician-gynecologists, and 3,000 surgeons.

The questionnaire, a one-page cover letter containing the University of California, San Francisco, Committee on Human Research approval number, the university's Experimental Subjects Bill of Rights, and a stamped return envelope were mailed in May 1990. The questionnaire was preceded by an announcement postcard and followed by a reminder postcard. The cover letter explained the purpose of the study, the nature of the selection process, and the procedures for establishing complete confidentiality and anonymity. Because of the sensitive nature of the study—several questions pertained to conduct that is classified as felony sexual assault in some states—we did not code the questionnaires to identify nonrespondents. Consequently, the response rate could not be increased by follow-up phone calls or second mailings to nonrespondents. The respondents were asked to return the questionnaire by July 30, 1990.

TABLE 1.—*Characteristics of Respondents*

Characteristic	Respondents* No.	(%)
Sex (n = 1,888)		
Women	282	(15)
Men	1,606	(85)
Age (n = 1,882), yr†		
<35	324	(17)
35-44	800	(42)
45-54	393	(21)
55-64	348	(18)
>65	17	(1)
Board certification (n = 1,886)	1,615	(86)
Sexual orientation (n = 1,882)		
Heterosexual	1,848	(98)
Homosexual	19	(1)
Bisexual	15	(1)

*The total number of responses for each question varied because some respondents did not answer all questions.
†Median = 42 years.

The anonymous responses were keypunched and verified. Unless otherwise noted in the text, χ^2 tests (with continuity correction) were used in the analysis. To avoid the assumption of equal variance, *t* tests were computed by a separate variance method. Kruskal-Wallis and Mann-Whitney U tests were done for ordinal variables. Sample sizes reported for the statistical tests vary because of missing data on a number of variables. Quotations have been edited for grammar and spelling.

Results

Characteristics of Respondents

Of the 10,000 physicians surveyed, 1,891 (19%) completed and returned their questionnaires. The respondents included 679 family practitioners (23% response rate), 360 internists (18%), 344 obstetrician-gynecologists (17%), and 489 surgeons (16%). Twelve uncompleted questionnaires were returned with unusable or hostile comments.

Table 1 characterizes the respondents. The respondents were representative of US physicians in sex and age, although they were overrepresented in board certification.[11]

Sexual Contact With Patients

A total of 176 (9%) respondents acknowledged sexual contact with one or more patients (Table 2). An additional 56 reported that in the most recent case, their sexual partners later became their patients; these respondents were not counted as involved physicians even though more than half reported sexual contact with multiple patients.

Of those responding, 164 (10%) men and 12 (4%) women acknowledged sexual contact with a total of 332 patients. Of the contacts for which both the physician's and the patient's sex were specified, 89% occurred between male physicians and female patients, 6% between female physicians and male patients, 4% between male physicians and male patients, and 1% between female physicians and female patients.

Of involved physicians, 42% had sexual contact with more than one patient. The largest number of contacts reported by a physician was 11. When asked about their most recent patient contact, involved physicians indicated that the duration of the sexual involvement ranged from one "sexual encounter" (17%) to "more than five years" (15%). Nearly two thirds (66%) of those involved with one patient and more than half (58%) of those involved with two or more patients reported that the sexual relationship lasted less than 12 months; 72% indicated that the most recent contact involved a current patient; and 28% indicated that the most recent contact was a "former" patient, using their own definitions of "former." Two physicians who were involved with "former" patients wrote that the sexual contact began within three months of a surgical procedure. Of those whose most recent contact was a "former" patient, 35% had been involved with multiple patients. A few (7%) sought consultation with a colleague concerning their sexual involvement with the most recent patient.

TABLE 2.—*Physicians Acknowledging Sexual Contact With Patients, by Specialty (n = 176)*

Specialty	Acknowledge Contact With 1 Patient, No.	Acknowledge Contact With ≥ 2 Patients, No.	Total Acknowledging Contact, No. (% of Respondents in That Specialty)
Family practice (n = 679)	42	30	72 (11)
Internal medicine (n = 360)	14	7	21 (6)
Obstetrics-gynecology (n = 344)	15	19	34 (10)
Surgery (n = 489)	29	16	45 (9)
Specialty unspecified (n = 19)	2	2	4
Totals	102	74	176 (9)

TABLE 3.—*Respondents' Opinions Concerning Sexual Contact With Patients**

Statement	All Respondents Agreeing With Statement		Uninvolved Respondents Agreeing With Statement		Respondents Who Acknowledged Sexual Contact With ≥ 1 Patient Agreeing With Statement		P Value
	No.	(%)	No.	(%)†	No.	(%)†	
It is professionally acceptable to have sexual contact with a current patient (n = 1,882)	122	(6)	78	(5)	44	(25)	<.001
It is professionally acceptable for a physician to have sexual contact with a patient still taking medication prescribed by that physician (n = 1,870)	221	(12)	162	(10)	59	(34)	<.001
It is professionally acceptable to have sexual contact with a patient whose treatment has stopped and who has been referred to another physician (n = 1,855)	1,173	(63)	1,016	(60)	157	(90)	<.001
I favor state licensing board regulations prohibiting physician-patient sexual contact (n = 1,828)	987	(54)	939	(56)	48	(30)	<.001

*The total number of responses for each question varied because some respondents did not answer all questions.
†Overall, 1,715 respondents were uninvolved, and 176 were involved.

Respondents' Opinions Concerning Sexual Contact With Patients

Virtually all respondents (94%) opposed sexual contact with current patients. In addition, 37% opposed sexual contact with former patients. Respondents rejected the use of physician-patient sexual contact to treat sexual dysfunction (97%), to enhance the patient's self-esteem (98%), or to change a patient's sexual orientation (99%). Numerous respondents considered it highly inappropriate for the sexual contact to occur during a consultation. "The physician's genitals have no reason to be uncovered in the workplace," stated a 32-year-old female obstetrician-gynecologist. Some respondents described physician-patient sexual contact as a breach of trust. "The physician-patient relationship is based on trust, care, and the patient's best interest. Sexual contact exploits and violates that trust," said a 43-year-old male family practitioner. A 44-year-old male family practitioner made an analogy with incest: "Physician-patient sexual behavior is a form of incest: [it] breaks the trust bond and destroys boundaries." A 60-year-old family practitioner wrote that he learned about the negative effects of physician-patient sexual contact through personal experience: "This [relationship] was disturbed; I didn't understand how or to what depth until years later when she [the patient] committed suicide."

TABLE 4.—*Respondents Whose Patients Reported Sexual Contact With Another Physician (n = 424)*

Specialty of Respondent	Respondents in That Specialty Whose Patients Reported Sexual Contact With Another Physician	
	No.	(%)
Family practice	170	(25)
Internal medicine	68	(19)
Obstetrics-gynecology	119	(35)
Surgery	62	(13)
Specialty unspecified	5	--
Total	424	(23)*

*Percentage is of 1,882 respondents.

Physicians who had been sexually involved with patients were significantly more likely than uninvolved physicians to approve of sexual contact with patients and to oppose regulations prohibiting such contact (Table 3). Involved physicians were also more likely to approve of sexual contact when the physician "falls in love" with the patient (Mann-Whitney $U = 166511$, $P < .001$): 60% of involved physicians deemed it "sometimes appropriate" (compared with 34% of the uninvolved), and 9% of the involved group considered it "always appropriate" (compared with 2% of the uninvolved).

Concerning policy recommendations, more than half of respondents favored state licensing board regulations prohibiting physician-patient sexual contact. "State licensing prohibition would have deterred me [from dating a patient], and I would support it wholeheartedly," said a 40-year-old female family practitioner. "It [physician-patient sexual contact] should be forbidden in state license applications which doctors sign. There are too many temptations and vulnerable people out there for this subject to be closeted the way it has been," commented a 61-year-old male internist.

Medical Treatment of Sexual Partners

Of all respondents, 39% considered it professionally acceptable to become the physician of a current or former sexual partner. Men (41%) were more likely than women (26%) to consider it acceptable ($\chi^2 = 21.4$ [*df* 1], $P < .001$). However, a 32-year-old male family practitioner cautioned, "I feel that it would be very difficult to remain objective in medical treatment with a sexual intimate. Are we not taught the hazards of treating our own family members?"

Patients' Sexual Contacts With Other Physicians

Nearly a quarter of respondents (23%) had had at least one patient report sexual contact with another physician. The specialties of these respondents are shown in Table 4. A total of 1,085 female and 54 male patients reported such contact. Respondents who were involved sexually with their own patients were more likely than uninvolved respondents to hear from patients about their sexual involvement with other physicians (37% versus 21%; $\chi^2 = 20.9$ [*df* 1], $P < .001$).

When asked about the effect on their patients of sexual contact with other physicians, 63% of respondents (including 38% of involved physicians) indicated that it was "always harmful." No respondent found it "always helpful." Female respondents and respondents who were not sexually involved with their own patients were more likely to assess sexual contact with other physicians as harmful to their patients (Table 5). A 45-year-old male surgeon commented on the four patients he had seen who had been sexually involved with other physicians: "The patients felt betrayed, but most were too ashamed to press charges."

Respondents' Education Concerning Physician-Patient Sexual Contact

More than half (56%) of respondents indicated that physician-patient sexual contact had never been addressed during medical school or residency. Only 3% had participated in a continuing education course that addressed this issue. Some were frustrated about such lack of education. For example, a 42-year-old male family practitioner wrote, "During residency the issue was never addressed. When [as a resident] I fell in love with a patient and refused to continue as her doctor (before any sexual contact), the faculty would not discuss the matter with me." A 35-year-old female family practitioner commented that "there are too many complex issues of power/dependence, sexuality, trust, and confidentiality involved in the physician-patient relationship to allow [it] to develop into a romantic relationship. These are issues that medical school didn't address at all!"

TABLE 5.—*Adverse Effects of Physician-Patient Sexual Contact According to 424 Respondents Whose Patients Reported Sexual Contact With Other Physicians*

Respondents	Find Such Contact "Always Harmful" to Patient(s)		P Value
	No.	(%)	
Female (n=68)	54	(81)	<.01
Male (n=356)	204	(60)	
Uninvolved respondents (n=360)	235	(68)	<.001
Involved respondents* (n=64)	23	(38)	

*Those who acknowledged sexual contact with their own patient(s).

Several younger respondents expressed gratitude that their training programs had addressed the issue. "I have been invited to become involved with female patients on three or four occasions, but medical school training helped me to handle these situations appropriately," wrote a 26-year-old male family practitioner.

Comment

Nearly one of ten physicians responding to this anonymous survey acknowledged sexual contact with their own patients. The prevalence of physician-patient sexual contact among our male respondents is consistent with a previous smaller study.[7] Our prevalence of sexual contact between women physicians and their patients is higher than previously reported. Only one of the California and New York women physicians surveyed by Perry[8] in 1976 had engaged in erotic contact with a patient.

While our response rate of 19% may limit our ability to generalize about physician-patient sexual contacts, inquiring about behavior that might be punishable as felony sexual assault may have diminished our returns. Some respondents commented that no physician living in a state that actively prosecuted physician-patient sexual involvement would ever return such a questionnaire. Other respondents may not have reported sexual involvement with their own patients out of a concern that such information might damage the credibility of the profession. The percentage acknowledging sexual contact with patients might have been higher if the physicians who received questionnaires had felt less inhibited. Even in the unlikely case that none of our nonrespondents had had sexual contact with patients, the prevalence of such contact among all 10,000 physicians surveyed would still be 2%. Furthermore, 23% of respondents reported sexual contact between their patients and other physicians—which suggests that self-reporting may underestimate the true prevalence of this problem.

Sexual contact between physicians and their current patients violates the fiduciary nature of the physician-patient relationship, which requires physicians to act for the benefit of patients who entrust their care to them.[12] When seeking medical care from physicians, patients are vulnerable because of their illnesses and dependent on their physician's medical expertise. To receive the care they need, patients must provide intimate information in the medical history, undress for a physical examination, and, for surgical procedures, allow their physician to violate bodily integrity. During this process, patients develop feelings of trust and respect for their physicians, as well as gratitude for the physicians' willingness to listen and ability to heal. Because feelings of trust, dependency, gratitude, and intimacy are inherent in the physician-patient relationship, patients may find it difficult to decline sexual initiatives from their physicians. Some patients, because of their vulnerability, may interpret their physician's professional caring as personal intimacy and even initiate sexual advances. It is the physician's responsibility, however, to prevent the harm that may result from physician-patient sexual contact.[12]

Sexual contact between physicians and their current patients may seriously harm patients.[5] In our study, two thirds of uninvolved physicians whose patients reported sexual contact with other physicians thought that such contact was "always harmful." This belief that sexual contact with physicians can harm patients is supported by the recent Ontario College of Physicians and Surgeons Task Force on Sexual Abuse of Patients.[5] The task force documented 174 cases of "clear substantive abuse" of patients who are sexually involved with physicians. Many of these patients felt exploited or betrayed when the sexual contact ended. Some reported that they were unable to trust subsequent physicians. Because a sexual relationship may interfere with professional objectivity, a patient who is sexually involved with her or his physician may receive inadequate medical care, especially with issues regarding pregnancy, sexually transmitted diseases, or psychologic health.[3] The task force concluded that these violations of trust in the physician-patient relationship were "devastating for the victim, usually in many aspects of her or his life, for the families affected, for the trust we place in the medical profession and for society as a whole."[5] We concur with most of our respondents, the AMA Council on Ethical and Judicial Affairs, and the Ontario College of Physicians and Surgeons that sexual contact between physicians and current patients is unethical.

Although almost all respondents in our study condemned sexual contact with current patients, they disagreed about the appropriateness of sexual contact between physicians and former patients. Physician-patient sexual contact was thought permissible by 63% if treatment had stopped and the patient had been referred to another physician. Some indicated that feelings of trust, dependency, or gratitude do not arise in all patient-physician relationships or may diminish over time. Even though our data do not support the contention that physician-patient sexual contact generally leads to long-term relationships—43% of involved physicians had sexual contact with more than one patient; most of these physician-patient sexual relationships lasted less than 12

months—several respondents cited personal knowledge of successful long-term relationships between physicians and their former patients. Others thought that physician-patient relationships should be judged on a case-by-case basis. They suggested that some patients could make autonomous choices to have sexual relationships with former physicians and would be no more likely to be harmed than by any other sexual partners.

The remaining 37% of respondents opposed sexual contact with former patients. The AMA Council on Ethical and Judicial Affairs agrees: "Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship."[2] That patients have been seriously harmed by sexual relationships with their former physicians has been documented.[5,6] Such relationships need to be considered carefully.

The issue is not how inconsequential the physician considered a previous interaction but, rather, how important the patient considered it. A patient's problem may seem routine or trivial to the physician but not to the patient. Suppose a physician meets a patient socially two years after a single clinic visit. The physician may have forgotten the original care, but can we be certain that the patient's dependency and gratitude have been extinguished, or that he or she is no longer vulnerable? For many patients, feelings that arise in a therapeutic relationship persist long after the episode of medical care.[3] Furthermore, in a brief visit most physicians are unlikely to have time to determine whether a patient had some special vulnerability, such as a history of sexual abuse, that might complicate relationships with authority figures. Thus, it may be impossible for physicians to be sure that they are not taking advantage of a previous physician-patient relationship to gratify their own needs.

For physicians to avoid harming patients, we suggest that they consider two guidelines before becoming sexually involved with a former patient. First, the professional relationship must have been terminated with no intent of future sexual involvement or a continuing social relationship. By termination, we mean that in the previous two years, there have been no office visits, no prescriptions written, no telephone consultations, and no return appointment reminder postcards.

We agree with the recommendation of the Ontario College Task Force[5] that at least two years must have elapsed since the last episode of patient care, with no social contact in the interim. The key issue is not time but, rather, a discontinuous relationship. A dating relationship between a physician and patient that began a month after termination of care would be inappropriate, therefore, even if the involved parties had refrained from consummating it for two years.

Second, the physician and former patient should meet again in a context entirely unrelated to the previous professional encounter. This helps ensure that the former patient is no more likely to be harmed than by any other possibly sexual relationship.

It is difficult to be objective during the early phases of a new relationship. Thus, both the physician and the patient may wish to discuss the incipient involvement confidentially with an advisor who will provide an honest appraisal of the potential harm to the patient, the physician, and the medical profession. Such counsel is a safeguard for physicians who might be inclined to act only on their impulses. Discussing such an intimate decision with an advisor—even anonymously—may seem intrusive, but it may remind physicians that such decisions are not completely private if they undermine public trust in the profession.

An unexpected finding in our study was that many respondents indicated that they treated their spouses, significant others, and former sexual partners. We did not ask whether such treatment involved serious medical illness. Although treating intimates for major medical problems is not unethical, it is unwise.[13] As one respondent wrote, "You can't be objective when you are emotionally involved."

Our finding that physician-patient sexual contact had never been addressed during the medical training of more than half of our respondents is disturbing. The need for education on this issue is evidenced by the fact that 23% of respondents had encountered patients who had been sexually involved with other physicians. The Ontario College of Physicians and Surgeons' Task Force[5] recommends comprehensive training on physician-patient sexual contact. We think that curricula should include these topics:

- Recognizing and managing nontherapeutic emotional responses to patients;
- Implications of the power dynamics between physicians and patients and women and men;
- The adverse effects of physician-patient sexual contact;
- The effect of physician-patient sexual contact on public trust in the medical profession;
- The legal implications of physician-patient sexual contacts (civil and criminal statutes).

Our study demonstrates that physician-patient sexual contacts occur despite professional ethical prohibitions. The potential for harm to patients from such contacts is serious. Physician-patient sexual involvement ultimately affects the credibility of the entire medical profession. We urge medical schools, residency programs, and continuing education courses to include teaching about this topic. A substantial educational effort will be required to prevent nearly 10% of the next generation of physicians from compromising patients' welfare and public trust in the profession.

REFERENCES

1. Campbell ML: The oath: An investigation of the injunction prohibiting physician-patient sexual relations. Perspect Biol Med 1989; 32:300-308
2. McMurray RJ: Report of the Council on Ethical and Judicial Affairs. Chicago, Ill, American Medical Assoc, 1990
3. Schoener GR, Milgrom JH, Gonsiorek JC, Leupker ET, Conroe RM: Psychotherapists' Sexual Involvement With Clients. Minneapolis, Minn, Walk-In Counseling Center, 1989
4. VanTuinen I, McCarthy P, Wolfe S: 9,479 Questionable Doctors Disciplined by States or the Federal Government. Washington, DC, Public Citizen Health Research Group, 1991
5. McPhedran M, Armstrong H, Edney R, Marshall P, Roach R, Long B: The Preliminary Report of the Task Force on Sexual Abuse of Patients. Toronto, Ontario, College of Physicians and Surgeons of Ontario, 1991
6. Felman-Summers S, Jones G: Psychological impact of sexual contact between therapists or other health care practitioners and their clients. J Consult Clin Psychol 1984; 52:1054-1061
7. Kardener SH, Fuller M, Mensh IN: A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients. Am J Psychiatry 1973; 130:1077-1081
8. Perry JA: Physicians' erotic and nonerotic physical involvement with patients. Am J Psychiatry 1976; 133:838-840
9. Gartrell N, Herman J, Olarte S, Feldstein M, Localio R: Psychiatrist-patient sexual contact: Results of a national survey—I. Prevalence. Am J Psychiatry 1986; 143:1126-1131
10. Gartrell N, Herman J, Olarte S, Localio R, Feldstein M: Psychiatric residents' sexual contact with educators and patients: Results of a national survey. Am J Psychiatry 1988; 145:690-694
11. Roback G, Randolph L, Seidman B: Physician Characteristics and Distribution in the US. Chicago, Ill, American Medical Assoc, 1990
12. Beauchamp TL, Childress JF: Principles of Biomedical Ethics. New York, NY, Oxford University Press, 1989
13. Bass LW, Wolfson JH: Professional courtesy is obsolete (Editorial). N Engl J Med 1978; 299:772-774